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ABSTRACT

It has been estimated that 85% of all women seeking therapy are adults molested as children (AMACs). Group counseling with AMACs is recommended, with groups having homogeneity in terms of presenting problems and heterogeneity in group members' ability to deal with their sexual abuse. Groups should be closed, meet once or twice a week for 2-hour sessions, have 6-8 members, and continue for at least 6 months. A three-stage model for group counseling with AMACs has been developed. Stage 1 goals are to establish a trusting and safe environment and a common bond among group members, and to get group members past the denial stage to admit that they were victims of sexual abuse and that the abuse has affected them. Stage 2 goals involve dealing with group members' feelings of rage, guilt, shame, and fear that emerge after denial is overcome. Gestalt Therapy seems to be the most effective treatment for this stage. Stage 3 goals involve helping group members to rebuild trust in themselves and others by correcting their distorted thinking and by teaching them coping skills for daily living. Cognitive-behavioral methods and assertiveness training seem appropriate at this stage. If treatment goals are met, group members will be able to accept themselves and their feelings and can begin to enjoy their lives. (NB)

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A MODEL FOR GROUP TREATMENT OF ADULTS MOLESTED AS CHILDREN

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A MODEL FOR GROUP TREATMENT OF ADULTS MOLESTED AS CHILDREN

THE PROBLEM

It has been estimated that 85% of all adult women seeking therapy were child victims of sexual abuse (Russell, 1984). Many practicing counselors are seeing adult women, suffering from a variety of symptoms, reluctantly beginning to reveal that they were molested as children. Signs and symptoms to look for have been extensively discussed (Butler, 1978; Emerson, 1985; Sgroi, 1984). Common presenting problems include depression, low self-esteem, self-hatred, suicide thoughts and/or attempts, recurring self-defeating behaviors, repeated "undeserved" vicitimization, substance abuse, unsatisfactory relationships, lack of trust, sexual problems, and memory loss of some portion of the childhood years. Clients may present one or more of these problems and not be victims of child sexual abuse. However, a combination of the problems mentioned should alert the counselor to the increased likelihood that the client has been molested. Indeed, more and more counselors are learning to ask at the intake interview if the client was abused as a child, and many women are admitting to this trauma.

Since one of the most successful coping measures used by sexual abuse victims is "shutting down" or taking their minds and feelings somewhere else, many victims of child sexual abuse quite literally do not remember what happened; such clients are not necessarily trying to withold information from their counselor; they simply cannot remember what happened. Other clients may remember but not want to believe what happened to them or not be ready to talk about it. Any discussions surrounding treatment for this population should include a consideration of this dynamic.

Learning what may have happened to a client, how she has reacted and been affected by it, and knowing what to do to help her are two separate issues. This article deals with the latter concern by suggesting one effective method of treatment: a group for female AMAC's (Adults Molested as Children). The authors have developed one model for such treatment.

RATIONALE FOR GROUP TREATMENT

The use of group counseling with victims of sexual abuse has been supported in the literature (Forward & Buck, 1978; Herman, 1981; Mayer, 1983; Wooley & Virgilanti, 1984). The rationale for using groups with this population begins with

the ability of a group to provide support and a forum for a common experience (Forward & Buck, 1978). The group may give members permission to talk about the experience, and in some cases even trigger the memories of those members who have repressed memories of abuse. Groups may help to reduce the sense of isolation and distance which often characterizes the incest victim's relationships (Faria & Belohlavek, 1984; Hall, Kassees, & Hoffman, 1986).

SCREENING, SELECTION, AND STRUCTURE OF THE GROUP

Most group practitioners agree that certain types of clients may not benefit from group counseling and indeed may hamper the group's progress (Bugen, 1977). Therefore, counselors need to screen potential members for this group as they would for any other group. Because of the nature of the AMAC population, a homogeneous group, in terms of the presenting problem, is recommended (Mayer, 1983). An all-female group who are all AMAC's will provide a safer and more game-free climate in which to develop support and cohesion. As Melnick and Woods (1976) have sugested, a more homogeneous group helps to ease discomfort and reduce anxiety. However, heterogeneity in the ability to deal with the fact of their sexual abuse has been recommended by Mayer (1983). A group composed of members who have difficulty accepting the reality of the sexual abuse, or that the abuse affects their current behavior might challenge even the most skilled group facilitator. A good mix might include some members who do not deny that the abuse occurred or that it has affected them, along with those who are still in some phase of denial.

Although 8-10 members has been sugested as the optimum size for adult counseling groups, we recommend 6-8 members because of the potential intensity of the treatment model. The group should meet for no less than two hours a session at least once a week. Twice a week meetings are preferable (Dinkmeyer & Muro, 1971). We recommend that a counseling group for AMAC's have a duration of at least six months.

Closed groups have been recommended for most counseling and therapy groups (Dinkmeyer & Muro, 1971); problems related to confidentiality and to the intensity of emotions which may be experienced also indicate that a closed group may be more beneficial for this population (Mayer, 1983). Trotzer (1977) suggests that, with sufficient care, new members can be added without causing too much disruption in the process, especially during the first few weeks, after which the group is closed.

A MODEL FOR GROUP COUNSELING WITH AMACS

A three stage model has been developed to work with this unique population. The model provides a framework within which the group counselor can adapt various treatment methods to his or her unique style. Co-facilitation has been recommended by Mayer (1983) because victim groups are typically unpredictable and intense.

STAGE 1.

Some victims of child sexual abuse who reach adulthood without any treatment of the their childhood trauma demonstrate considerable denial. They may deny that the sexual abuse happened at all; they may say that they dreamed that such things occurred; or they may have no memory of the events surrounding the abuse. If they do remember the sexual abuse, they may have convinced themselves that its occurrence has not affected them. Such clients often appear to be in complete control of their emotions and may spend a lot of time in the group talking about how wonderful their lives are now or how they have "overcome" their unhappy childhood experiences. These group members may have difficulty sharing their incest experiences or disclosing why they are in the group.

The goals for the first stage are similar to those of any other group in establishing a trusting and safe atmosphere along with establishing a common bond among group members. In addition, the treatment goals for the particular problem common to all the groups members are: to accept that they were victims of sexual abuse--that the abuse did occur; and to accept that being a victim of child sexual abuse has affected them--their feelings about themselves and their relations with others (Courtois & Watts, 1982). It is important for group members to face the abuse and admit it has taken place in order to break the pattern of secrecy and denial which they have had most of their lives (Forward & Buck, 1978).

To help members get beyond the denial stage, it is important for the leader to have worked through his/her own attitudes and feelings about incest or child sexual abuse (Courtois, 1979). The leader who responds defensively or in a judgmental manner to either the denial or the discussion of the abuse will hinder the movement of the group. Group leaders should also avoid the "compassion trap" (Phelps & Austin, 1975)--reacting too sympathetically or treating members as more traumatized or fragile than they really are.

The facilitative conditions of genuineness, warmth, acceptance, and empathic understanding are necessary to build a safe environment (Hansen, Warner, & Smith, 1982). Giving

information about the common effects of sexual abuse on normal adult functioning may serve to neutralize any embarrassment about discussing this topic in the group. The counselor may also need to use gentle confrontation when dealing with some aspects of the group members' denial. A confrontation which picks up on the discrepancies in clients' own utterances can be used to help group members face the problem.

STAGE 2.

Being able to accept the fact that they were sexually abused, or being able to talk about it for the first time in a safe environment initially may produce a feeling of release which amounts to euphoria. But those feelings soon give way to other feelings: rage, guilt, shame and fear (Forward & Buck, 1978; Wooley and & Vigilanti, 1984). The goals for Stage 2 involve dealing with these emerging negative feelings.

The predominant feeling which emerges is usually anger (Herman, 1981). The victim of child sexual abuse may initially just feel rage. Then as the anger begins to be differientiated, it may be directed at the person who should have protected her (usually the mother) and then later at the person who abused her (usually the father or other male relative). The victim may feel angry at the system for not believing her or helping her. She may also feel anger at others who were not abused and so have not been "through" what she has.

After the initial explosion of rage, incest victims often experience feelings of grief and loss (Herman, 1981). The group member may grieve for her lost childhood or for the fantasy parents she never had. Guilt and shame often emerge. Victims of child sexual abuse often feel that they somehow asked for the sexual relationship or caused it, that it is their fault, or that they deserved what happened to them. Victims may be fearful of talking about the abuse because of their childhood experience of not being believed when they did tell someone, or of the threats from the perpetrator which kept them silent. They also may fear men and may not trust women (Courtois & Watts, 1982). Victims of child sexual abuse typically have very low self-esteem; feelings of worthlessness and self-hatred are not uncommon (Hall, Kassees, & Hoffman, 1986). Depression is almost universal. Group members who are not able to work through these feelings remain stuck in the pattern that helped them to survive their childhood experience, and thus stuck in the role of victim (Faria & Belohlavek, 1984).

Because of its emphasis on re-experiencing the unfinished business of the past in the present, and of owning and staying with feelings in the now, we have found Gestalt Therapy to be the most effective treatment for this stage of the group. We recommend a modification of the traditional Gestalt group which focuses on a one-on-one interaction in the group setting between a group member and the leader. The modification encourages group interaction at the beginning and at the end of the group to provide for support and feedback from other members. One-on-one Gestalt therapy is used when members work individually on issues.

The concept of "peeling the onion" (Perls, 1973) can be used to help group members to look below the surface as they move from denial (phony layer) to resistance to the impasse where the choice is to face their pain or to continue to live as prisoners of their past. Specific techniques or exercises which are useful at this stage include the game of dialogue, making rounds, I have a secret, playing the projection, and exaggeration (Levitsky & Perls, 1970). The use of guided imagery or fantasy can often ease the transition from denial to feeling. Group members can be asked to imagine that acts of sexual abuse are recorded on film or tape which they may roll backwards or forwards, as they project their lives on the wall. They can stop the film whenever they choose. Another useful experiment combines role reversal and imagery. Group members can pretend to be the parent they always wanted to have, using a baby doll or a pillow "baby" which each member holds as she plays the role of her own parent, telling "Little____" what she wanted to hear from her parents.

When clients begin to own their feelings, and stop accepting the blame for the abuse, they will begin to be more accepting of themselves. Group members will begin to look better physically, be more relaxed, smile more; they will report that they feel better. Group members are now ready to begin work on behavior change and to make new decisions about their lives.

STAGE 3.

Many women have difficulty with faulty perceptions and beliefs about themselves. Women who have been abused have these faulty beliefs even more firmly entrenched. Several authors have suggested that techniques from the cognitive therapies be used in treating sexual abuse victims. Mayer (1983) suggests that group members may benefit from cognitive insights following experiential work. Faria and Belohlavek (1984) found cognitive therapy to be useful in correcting the distortions in the thinking of incest victims. AMAC's,

because of the nature of their abuse, need to change their view of themselves, faulty perceptions about the sexual abuse and faulty perceptions about other people. The treatment goal in Stage 3 involves helping group members to rebuild trust in themselves and others by correcting their distortions in thinking and by teaching them skills to cope with their daily lives.

Changing the negative view of oneself involves accepting oneself and one's feelings. It also involves viewing the sexual abuse in a different light. Instead of seeing heself as something evil or dangerous (Herman, 1981), the group member needs to begin viewing herself and her parents in a more realistic light. An important step in changing self-defeating perceptions, and thus behavior, involves taking risks. The incest victim may have avoided confronting family members and she may have avoided close relationships with men or women. Incest victims typically have allowed themselves to be victimized in other situations and in other relationships (Hall, Kassees, & Hoffman, 1986). Learning to trust others involves learning to trust themselves--learning to stand up for their rights, to say "no," to ask for what they want, and to communicate directly and honestly.

Cognitive behavioral methods seem to be appropriate at this stage because the task at this point is to correct the faulty perceptions of the victims of sexual abuse (Mayer, 1983). Teaching the group members that they can change their feelings by changing how they perceive events in the past and in the present has been found to be an important tool in combatting both depression and self-defeating behavior (Beck & Greenberg, 1974; Sank & Shaffer, 1984).

Because cognitive methods involve an education process (Ellis, 1975), the group counselor(s) will begin Stage 3 by teaching group members about irrational beliefs and absolutistic thinking. Then as each member discusses her feelings and beliefs about the past incest or current problems, the counselor encourages other group members to help challenge and dispute the faulty thinking which emerges. However, while challenging a member's errors in thinking, the leader and members remain supportive of the victim and of her efforts to move beyond her victimization.

Most cognitive approaches vigorously advocate homework assignments (Sank & Shaffer, 1984). Initially, the homework will involve having members practice self-talk outside of the group. They are encouraged to practice challenging their irrational thoughts daily by repeating rational statements, examining their thoughts and feelings, and by posting

reminders on mirrors or refrigerator doors that say: "I am o.k." and "It is o.k. to be angry at those who abused my trust." They can be asked to write and speak affirmations as part of the healing process. Activity-oriented homework assignments, such as in vivo risk taking (Ellis, 1975) or performance of certain tasks, can also be used. When using homework assignments that involve activities outside the group, it is important to begin with easy tasks so that group members will have more chance of success (Beck & Rosenberg, 1974).

Assertiveness training is very important for this population. As children they often had to submit to the will of others. As adults they are passive and do not stand up for themselves. After members can identify and dispute their irrational beliefs, the group can be used to practice assertive skills as well as other social skills. The areas outlined in Phelps and Austin, The Assertive Woman (1975), produce a comprehensive program to round out group treatment.

If the goals for treatment are met, group members will be able to accept themselves and their feelings. They will increasingly develop positive feelings about themselves and begin to trust themselves and others. They can begin to enjoy sex, to risk in relationships, to experience healthy intimacy and fulfillment. They will give up being victims, learn to stand up for their rights, and refuse to be used by anyone. Instead of dreading life, they can begin to enjoy it.

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